

DETF HEALTH INSURANCE FORMS ORDER

Employer Name: _____

Employer Number (EIN): 69-036 _____

Employer Mailing Address: _____

Your Name: _____

Your Phone Number: _____

FORMS

<u>Form Name</u>	<u>Form Number</u>	<u>Quantity</u>
Health Insurance Application	ET-2301 (rev. 9/2003)	_____

Fax this completed form to:
Supply and Mail Services, (608) 267-4549

Or mail to:
Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

